ETHICAL AND CLINICAL CONCERNS FOR INCARCERATED PREGNANT WOMEN AND THEIR CHILDREN

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ABSTRACT

In 1976, the legal ruling of the case *Estelle v Gamble* established the precedence of evaluating unjust healthcare practices and violation of Eight Amendment rights to prisoners. Since this ruling, numerous cases have appeared in court of law due to the mismanagement and mistreatment of pregnant women while incarcerated. The practice of mass incarceration within this country has contributed greatly to the number of women behind bars without the necessary establishment and practice of healthcare to address women's health needs and care during pregnancy. Shackling of incarcerated women throughout the course of their pregnancy and the practice of separating the child immediately at birth is evidence of the continuation of unacceptable healthcare practices occurring in the United States of America. To understand this topic and the issues involved, an understanding must be gained of the history, legal course, and dangers faced by incarcerated pregnant women.

Dedicated to my mother

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CHAPTER 1: INTRODUCTION

On July 14th, 2018 Diana Sanchez was booked into the Denver county jail. At the time she was noted by medical professionals at the facility to be approximately 8 months pregnant with an expected due date of August 9th. On the morning of July 31st, she began to experience contractions and attempted to notify the supervising deputies for assistance. The deputies alerted the nurse, who according to the report was the only available medical staff at the time, however there was no response by the staff to her onset of labor. She gave birth alone and without assistance, witnessed only by the video surveillance monitoring in her cell. It was only after the birth of her child was complete that a medical provider finally presented themselves to her cell and proceeded to separate the newborn from mother.

The story of Ms. Sanchez represents a well-rooted history and campaign of an attack on the motherhood and personhood of incarcerated women. The current and historical practice of healthcare for incarcerated pregnant women highlights that they have and will continue to be an ignored population within our society whom are denied a fundamental right to healthcare and well-being. This thesis serves the purpose of exploring ethical and clinical concerns faced by incarcerated pregnant women, recognizing the intersections of race and motherhood. I wish to provide, at the least, recognition to incarcerated woman as a group that should be viewed in special interest within conversations of and movements for social justice.

CHAPTER 2: PRISON HEALTH AND HEALTHCARE

As a fourth year medical student, I entered my last year of medical school preparing to apply for residency in Ob/Gyn by completing a clinical rotation in Maternal Fetal Medicine (MFM), a specialized practice within the field of Ob/Gyn focusing on the care of high-risk pregnancies. After reviewing the list of patients for that day, I volunteered to help care for a patient who was transferred from a nearby prison requiring evaluation for elevated blood pressures. I entered the patients room on the highly secured labor and delivery unit to find her arms handcuffed to the bed with two armed guards sitting on the other side of the hospital bed with their guns clearly visible.

The site of the patient's arms restrained and the outward display of guns in a hospital labor and delivery unit seemed unnecessary. On previous clinical rotations I witnessed the use of restraints on patients for various reasons; mainly to protect the patient from harming themselves or compromising their care in some way. In my evaluation of the patient, I could not identify any indication consistent with what I have learned for her to be restrained. There was certainly no risk that I could identify of the patient harming themselves or anyone else. Therefore, not only I have a feeling that the use of the restraints was unnecessary, I could not identify a reason to justify the use. From my evaluation, the use of the restraints only added additional discomfort to what the patient was already experiencing with her pregnancy.

I presented the patient to the MFM team; which included myself, the MFM attending physician, two resident physicians, and a third-year medical student. At the end of my presentation where I provided a summary of the patient's medical history, elevated blood pressure and recommendations of how to direct our care for her, I then handed each

person on the team a copy of the state of Pennsylvania Prisons and Parole Code Title 61 Section 5905. I read to the group, "the correctional institution staff accompanying the prisoner or detainee shall immediately remove all restraints upon request of a doctor, nurse, or other health care professional." We then followed the attending physician in the room who agreed with my assessment that there was no indication for the use of restraints and asked the guards for removal.

From this experience, I discovered an injustice that I had previously never encountered before. I then found the story of Diana Sanchez. I understood that there was a much larger issue beyond just the use of shackles on pregnant women. I pursued to understand the injustices incarcerated pregnant women face so that I may be better able to respond when encountered again.

The legal precedence applied in the case for Diana Sanchez is derived from the 1976 case of *Estelle v. Gamble.* J.W. Gamble was a prisoner at the Texas Department of Corrections who suffered an injury during a prison work assignment.[1] From this case the court established that a "deliberate indifference by prison officials to a serious illness or injury can constitute cruel and unusual punishment in violation of the Eight Amendment, which is written in the U.S. Constitution as excessive bail shall not be required, no excessive fines imposed, nor cruel and unusual punishments inflicted.[2] In the case for Gamble, however, the court did not establish a deliberate indifference with regard to providing medical care as it was documented that they were examined by medical professionals 17 times during the course of the injury. Ultimately, the standard and test of "deliberate indifference" was established to ensure that a prisoner is not denied necessary medical treatment protection of prisoner's Eight Amendment rights.

Since the 1970s, multiple legal cases have required the evaluation for violation of prisoner's Eighth Amendment right related to medical care. In 2018, two doctors were charged with malpractice as a court determined a deliberate indifference in medical care toward prisoners resulting in brain injury, a vegetative state and eventual death. [3] Another case in 2019, involved a Virginia inmate who was improperly treated ultimately leading to permanent injury.[4] Similar to the story of Diana Sanchez, there was a recent case in 2019 of a woman named Tammy Jackson who was forced to give birth alone in her cell without proper medical attention at a correctional facility in Florida.[5] Since the 1976 case of *Estelle v. Gamble*, the violation of the Eighth Amendment rights of prisoners continues, especially for incarcerated pregnant women.

The case of *Boswell v Sherburne County* not only presents the issue of healthcare negligence and violation of prisoners Eighth Amendment rights, but how such violations and negligence are protected by their own precedent legal rulings. In 1988, Wanda Charlene Boswell was arrested for driving under the influence of alcohol and taken to Sherburne County Jail in Elk River, Minnesota. Upon booking, it was acknowledged by jail staff that Boswell was around 26 weeks pregnant and were notified by Boswell that she was experiencing a complicated pregnancy with active vaginal bleeding and episodes of syncope in the days prior. Her health, her pregnancy, and her unborn child were not addressed at this time and she continued to experience bleeding while confined in the jail. Her condition progressed to severe cramping and pain but according to the reports, was denied release to a hospital until her bond was paid. Over the next 10 hours her condition worsened significantly, forcing jail officials to call an ambulance to transport Boswell to

a hospital where she gave birth to a baby boy who passed away 34 minutes later. The case ended in a settlement between the involved parties.

Boswell and her representing legal team argued that the jail officials committed deliberate indifference toward responding to her medical needs, health and pregnancy which ultimately violated not only her Eighth Amendment rights and added that her Fourteenth Amendment right was violated as well. The Fourteenth Amendment states that "all persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall […] deprive any person of life, liberty, or property, without due process of law."[6]

The involved jail officials in the case of Boswell based their defense from a ruling from *Harlow v Fitzgerald* which established that "government officials performing discretionary functions, generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known."[7] The jail officials argued that their obligation to medical treatment for Boswell was not clearly established at the time of the incident and therefore they are immunized from any related claims that violated her constitutional and amendment rights.

Analysis of the application of this defense argument is based on that of a "reasonable person" and their ability to recognize a persons need for medical attention. While the involved jail officials claim that their role to oversee her state of health was not defined prior to or at the time of Boswell being in their custody, the fact that she was in their custody includes a responsibility to ensure safety and well-being. Certainly a "reasonable person", even one without higher levels of medical knowledge and training,

can recognize that active bleeding deserves some attention. The ruling of this case was decided in favor of the jail officials, protected by their claim to not be responsible for Boswell's medical needs despite being in their custody and unable to seek medical attention herself.

The precedence established in the ruling of *Harlow v Fitzgerald* is meant to serve to protect individuals, such as the involved jail officials, from having to address health concerns for which a "reasonable person" cannot recognize. However, in consideration of the role that the jail officials were evaluated and hired to fulfill, one would hope to believe that they as "reasonable persons" and can recognize that vaginal bleeding and worsening cramping in the setting of a pregnancy deserves medical attention. However, outlined from these legal cases and rulings is a clear standard of providing healthcare that differs from that provided to the general public placing incarcerated pregnant women and their unborn children at risk.

As a result of the legal cases discussed and many more addressing issues of prisoner healthcare, a national effort began to address the ongoing concerns for healthcare provided within the prison system. A 1973 report published by the American Medical Association (AMA) prompted movement toward establishing healthcare pilot programs in select correctional facilities in order to address the findings from the report of inadequate care for prisoners. This report found that out of the 1,159 jails included in the national survey; 66% had first aid capabilities, 38% had physicians available on-site to provide care on a regular basis, and in 32% there was no physician available at all to provide care when needed.[8]

Resulting from these pilot programs and the data from the national survey, the National Commission on Correctional Healthcare (NCCHC) was formed in 1983 to serve as an accreditation service for those correctional facilities that choose to have their standards of the healthcare services evaluated. In 1987, the NCCHC released a follow up report to the 1973 findings of the AMA stating that "the basis of the standards is the belief that the health care provided in penal institutions should be equivalent to that available in the community, and subject to the same regulations" and that the "accreditation on the basis of these standards is the foundation for the professionalism and public support of correctional care as a specialty."[9] However, despite the creation of the NCCHC and its evidence based concluding statements, accreditation of healthcare provided correctional facilities by the NCCHC remains voluntary. Out of the number of correctional facilities within the U.S., including juvenile centers, jails, and prisons, it is unclear how many of these facilities take part in accreditation by the NCCHC as that data is not published. Due to policy the NCCHC is not ablet o provide a list or number of correctional facilities currently operating their healthcare services to prionsers under their accreditation.

Some of the best greatest improvements to healthcare for prison inmates can be credited to prisoners themselves and not from those operating within leadership roles of prisons and government. In the 1977 case of *Todaro v Ward*, a civil rights class action suit was brought forth by a group of incarcerated women against Bedford Hills Correctional Facility in Westchester County, New York. This group of women claimed a violation of their eighth and fourteenth amendment rights and it was determined after the "deliberate indifference" test was applied, that the facility was in fact guilty of not

properly screening for women's health issues.[10] The facility was also found guilty of poor administration of healthcare services and unreasonably delayed medical care to prisoners. As a result of this ruling and the efforts made by the inmates to successfully advocate for their own rights, the court ordered Bedford Hills Correctional Facility to improve healthcare administration of the facility. Following the orders of the court, Bedford Hills Correctional Facility now serves as a national model for healthcare administration to prisoners, most notably known for their prison nursery program.

Currently, 62.9% of female prisoners are between the ages of 26-45, within reproductive age, and 58% with 10-20 year sentences. It is also important to understand that the majority, 45.3%, of the offenses committed resulting in incarceration are non-violent and drug-related.[11] To understand just how many women experience pregnancy during their time incarcerated, in 2017 Johns Hopkins University published a study where a sample amongst 22 state and federal prisons found that 1396 women were pregnant at the time of intake.[12] This study found that from these recorded pregnancies, 753 resulted in live births, 46 in a miscarriage, 4 still births, 30 cesarean sections and 6% as preterm births. Despite a small sample, these study holds its importance as currently the only data collected specific to the birthing outcomes of pregnant incarcerated women.

Birthing outcomes of pregnant incarcerated women is an area needing further attention due to increased risk to health of both mother and child specific to the status of being incarcerated. Based on the number of legal cases and published reports, there is clearly an unacceptable and lack of healthcare provided to pregnant women who are incarcerated. In addition, birthing outcomes must also be addressed with attention to other risks that incarcerated pregnant women face, specifically substance abuse. A report

published by 1993 the University of North Carolina identified the lifestyle risks present in a sample of pregnant incarcerated women. This report found that within the sample of incarcerated pregnant women included in this study; 57.3% were actively using tobacco, 27% actively using drugs, and 15.5% using alcohol.[13] In 2012, the United States Department of Human Services conducted a national survey and found that of pregnant women out of the general public, 15.9% reported use of tobacco, 5.9% reported use of illicit drugs, and 8.5% of alcohol use.[14] This data reveals that pregnant women who are incarcerated, compared to the general population, are actually at increased risk to the use of substances that are harmful to their own and the health of the fetus.

CHAPTER 3: MASS INCARCERATION OF MOTHERHOOD

The continued struggle faced by incarcerated persons to uphold their amendment rights based on the precedent ruling from *Estelle v Gamble* in 1976 is notably reflected in the case *Brown v Plata* in 2011. This case involved a Supreme Court decision to depopulate California prisons in order to minimize the potential health risk to inmates as a result of overcrowding.[15] The decision for the state of California to depopulate its prison system was reaffirmed by the Supreme Court which found a correlation between the lack of resources to provide healthcare and the overcrowded prison system. The Supreme Court stated that suffering resulting from lack of medical care, including mental health services, as a result of overcrowding is "incompatible with the concept of human dignity and has no place in civilized society."[16]

The growth and development of the U.S. prison system has largely resulted from a directed campaign to place bodies within its walls. The fact that the healthcare system within U.S. prison system did not grow and develop alongside its population, despite the major advancements in the U.S. healthcare system, is evidence of the view held by our society and governing bodies that those incarcerated are non-deserving of the right to health and well-being. Some will argue that the decision by those individuals incarcerated to commit a crime does in fact lessen their deservingness to health and well-being. This is supported by an idea that the decisions an individual makes resulting in arrest and confinement are acts that must also be punished with a loss of basic human rights. However, when understanding the growth and development of the prison system as a result of a directed mass incarceration campaign, it is understood that incarceration

operates to purposely and selectively criminalize groups of people based on race, gender, and motherhood.

The practice of mass incarceration has its origins from slavery. The same theory of enacting physical control over another person's physical body to better them through slavery is the same theory for which drives the structure of what is called the "correctional" system. For slavery, justification came from viewing the enslavement of Africans as ordained by God. At an early time when the enslavement of African peoples was debated on its ethical and moral foundations, Pope Nicholas V provided the Portuguese crown an answer in the papal bull *Dum Diversas* of the year 1452 instructing the Portuguese and other enslaving nations to "invade, capture, vanquish, and subdue all Saracens, pagans, and other enemies of Christ, to put them into perpetual slavery, and to take away all their possessions and property."[17] In the modern prison system, the justification of incarceration and physically obtaining control over another individual's body by the nation state, is argued to be done for the purpose of "rehabilitation" as they are viewed as enemies of our society and law for the actions they committed.

With emancipation our social and political governing systems were faced with the issue of freed Black bodies. Through the use of violence supported by law, Jim Crow offered a solution to once again control Black bodies. Jim Crow differed from slavery in that there was an added motivation to eliminate Black bodies which were no longer valuable in use as labor and certainly not included in the vision of a growing United States of America. Possession was reconfigured within our social and governing systems to suppression and elimination. The result of the Civil Rights Movement again presented

the issue of "freed" Black bodies, with the practices of Jim Crow outlawed. The answer then, and continues to be, is incarceration.

In 1965, the Law Enforcement Assistance Act was passed to allow government a direct role in efforts to militarize local police forces. Efforts continued with President Richard Nixon's success in decreasing funding welfare programs and increasing policing. During the 1980s, the war on drugs was ushered by President Ronald Reagan increasing the total prison population from 50,000 in 1980 to 400,000 by 1997 for nonviolent drug offenses. During this time as well, the national war on drugs received assistance at the state level with California's passage of the three strikes law in 1994. As a result, the efforts of both controlling and eliminating Black bodies were successfully reconfigured from slavery and Jim Crow to incarceration through the war on drugs. However, The National Review published a report in 1996 concluding that despite major efforts, "the war on drugs is lost"; including the number of lives unnecessarily locked behind bars.

When analyzing prison data from this era of mass incarceration, special attention must be directed to the specific campaign targeting incarcerate women. The Federal Bureau of Prisons reported on July 13th, 2019 that the total U.S. prison population was 179,862. Of this total population, 7.1% were female.[18] According to an analysis report by the Federal Bureau of Statistics, from 1990 to 2000, the number of female prisoners increased 108%, compared to 77% for males. In addition, the report finds that the annual growth rate for incarcerated women is 7.6% compared to 5.9% for males, showing women as the fastest growing segment of the prison population.[19] From 2000, the total U.S. prison population has increased from 145,125 to 176,322, a 21.5% increase.[20]

Given the dramatic increase in the total U.S. prison population since the beginnings of the war of drugs and the contributing rate at which the female prison population continues to increase, this continued era of mass incarceration must also be viewed as a direct campaign not only to control and eliminate Black bodies, but as a direct attack against women, women's health, reproductive rights, and motherhood. This directed campaign against women can be thought to further achieve the objectives once fulfilled by slavery and Jim Crow but now attacking the very source for which Black bodies are formed.

The criminalization of drug and substance use has and continues to be largely influenced by race. Governing and policing response, historically, to substance abuse in this country depends on what group of people are association with use of that substance. Discussion of substance use among incarcerated pregnant women reflects a larger systemic and societal issue not only toward the racialized criminalization of substance use, but furthermore toward a direct attack of motherhood.

To understand the racialization of criminalizing substance use and its efforts to attack mothers and pregnant women, I analyze aspects of government and policing response during the crack epidemic versus the current opioid epidemic. With the majority of women incarcerated overwhelming representing women of color for nonviolent drug offenses, such an analysis reveals how the racial criminalization of women during the crack epidemic compared to the opioid epidemic, established the past and continued population of pregnant women incarcerated.

In 1991, *Time* magazine published the "Crack Kids: their mothers used drugs, and now it's the children who suffer" displaying across the cover a close up image of a child

in tears and clearly suffering. Contrast the image used to represent the crack epidemic with that used by *Time* magazine to represent the opioid epidemic. In 2018, the cover of *Time* magazine read "The Opioid Diaries" with an image of a person's silhouette as they insert a needle into their arm. The identity of the individual in this image is protected and therefore no individual person and group is placed at blame. In fact, the image used by *Time* magazine to present the opioid epidemic is designed to formulate an empathetic response by the public toward those affected by opioid use disorder, largely a white population. Even the language appearing on the covers serves this purpose with the use of "diaries" allowing readers to understand the life of the person in the image and the challenges they face with substance use.

Figure 1: Time Magazine covers

This is in contrast to the image presented to portray the crack epidemic, largely affecting Black communities, which does not draw readers to empathize or gain understanding to the challenges they face with substance use. Rather the cover and its image of a suffering child invokes emotions of anger and hate. The words "crack kids" displayed on the cover followed with the remaining title influences the viewer to associated the child's pain directly to their mother's actions. There is no attempt to

understand the life or person behind the substance use, instead its an attempt to blame. The identity for those associated with the crack epidemic is not protected nor is the viewer drawn to empathize with the life of the person suffering from substance abuse. In fact, for the portrayal of the crack epidemic, that person is not even represented only by its negative impact on society which is absent in the cover representing the opioid epidemic which has a significant burden on our healthcare system and society.

Furthermore, the attempt to humanize those with opioid use disorders in contrast to those associated with the crack epidemic, *Time* also published a series of photos of people, majority of them white, from the community of Kensington, located in Philadelphia near to wear I attended medical school. With the title of "Kensington Blues" the reader is taken through a series of photos as a further attempt to develop empathy for those who suffer from opioid use disorder. It is also important to note, that *Time* magazines portrayal of the opioid epidemic, does not attempt at all to specifically attack woman and mothers who suffer from opioid abuse as it does covering the crack epidemic. The crack epidemic portrayal by *Time* primarily influences the reader to blame the issue occurring at the time directly on woman and mothers.

The same attack on motherhood by *Time* magazine, reflecting criminalization of the crack epidemic compared to the opioid epidemic, is also reflected in laws and policies addressing the use of these two substances of abuse by women during pregnancy. In 2018, the Pennsylvania Supreme Court ruled that a mother's use of opioids during pregnancy is not considered civil child abuse under the Child Protective Services Law which defines a "child" excluding a fetus or an unborn child.[21] Therefore, a mother's use

of drugs during pregnancy does not qualify as child abuse because the affected fetus is not considered a child by law at the time of the substance use.

This ruling came as a result of a child born at Williamsport Hospital, outside of Philadelphia, in 2017 who required treatment for Neonatal Abstinence Syndrome (NAS) following birth. NAS can result when a newborn is born to a mother who was using opioids during the pregnancy, as well as from other substances including tobacco. The potential complications to the newborn include impacts of neurodevelopment outcomes resulting in intellectual disability and withdrawal requiring treatment.

The mother in this case had a history of substance abuse and enrolled in a treatment program four months into the pregnancy at the time she learned of her pregnancy. She was released from jail two weeks prior to the birth of her child and afterwards tested positive for opiates, benzodiazepines, and marijuana. The child was taken into emergency protective services and the mother accused of child abuse. The Supreme Court's ruling did not uphold the charge of child abuse. The ruling of the Pennsylvania Supreme Court in 2018, protecting mothers with substance use, despite negative outcomes suffered by the child after birth, reveal the difference of the racial rhetoric between the use of opioid and crack cocaine. The ruling of the Pennsylvania Supreme Court in 2018 must be viewed in the context of taking place during the opioid epidemic versus rulings of similar cases which took place during the crack epidemic.

In 1996, the South Carolina Supreme Court upheld the conviction of Cornelia Whitner for criminal child neglect, sentencing her to 8 years in prison as a result of her admitted cocaine use during the third trimester of her pregnancy.[22] Compared to the Pennsylvania Supreme Court ruling, the South Carolina courts during this time extended

the definition of a "child" to include a viable fetus. In the 1996 case of Cornelia Whitner the drug of abuse was crack cocaine, occurring during the height of the crack epidemic largely affecting Black communities, and Whitner herself was Black.

Compared to the 2018 case that took place in Pennsylvania, the identity of the person and their race were protected and not released beyond the use of the initials "A.A.R." The attempt to protect A.A.R.'s identity compared to the public outing of Whitner, her race, and her substance of abuse, reflects the difference also observed between *Time* magazines portrayal of the opioid epidemic and the crack epidemic. In addition, Whitner was ultimately convicted and incarcerated for abusing substances during her pregnancy, however, it is unclear whether or not her child displayed symptoms following birth associated with crack cocaine use during pregnancy, if the child tested positive for the substance, or if they required treatment as a result. Legal and societal response to the opioid epidemic in the case of A.A.R. was to protect the mother empathizing for her addiction to opioids and have laws in place to do so, despite the facts of the case clearly stating that her child did in fact become symptomatic and required treatment as a result of her use of opioids during pregnancy.

Certainly, both the use of crack cocaine and opioids, including heroin, present equally concerning risks to both mother and fetus during pregnancy. Both substances should be addressed with the same concern for potential adverse outcomes of health for mother and fetus. What must be recognized however is that the differences in rhetoric, response, and ruling discussed has and continues to contribute to the campaign of mass incarceration and attack on motherhood. This understanding provides reasons as to why

the female prison population has increased in number by 108% from 1990 to 2000, many of those women may still remain incarcerated.

In 2014 Tennessee became the first state to specifically target and criminalize women for the outcomes of pregnancy related to the use of drugs and alcohol. The drafted law stated that any woman can be charged with aggravated assault, carrying a maximum sentence of 15 years, if it is proven that the adverse outcomes to the fetus and/or the presence of an addictive substance in the baby is proven to be caused by the mother's actions during the course of the pregnancy.[23] The law also included specific protections, for which the mother may not be prosecuted if they enrolled in a rehabilitation or treatment program at any time during the pregnancy before the child is born, remained in the program after delivery, and continued on to successfully complete a long-term treatment program. The purpose of this law by its makers was to punish women for substance abuse issues they face instead of providing them first and foremost with proper treatment to prevent adverse health events for both mother and child.

While this law was designed to discourage and ultimately prevent pregnant women from the use of harmful substances during the course of their pregnancy, evidenced by its reversal the result was that this law actually discouraged pregnant women with harmful substance use to seek prenatal and medical care during their pregnancies due to fear of facing criminal charges. This law that was designed to prevent harm to the fetus ultimately resulted in an increased risk to the health of the fetus and mother due to absence of necessary and vital prenatal care. Since its reversal, supporters of the original passage continue to try to reenact the law as the Tennessee Fetal Assault bill. The status of this new bill is still to be determined.

CHAPTER 4: SHACKLING PREGNANCY

While on my MFM rotation as a fourth-year medical student, I encountered the patient transferred from prison and handcuffed to the hospital bed in August of 2019. At the beginning of that month, Pennsylvania amended the state act on Prisons and Parole to add new provisions for medical professionals to address the use of shackles on pregnant patients within a hospital setting. Prior to this amendment, Pennsylvania did not grant physicians or other medical providers the authority to order the removal of restraints, even when medically necessary. In June of 2019, a summative report by the American College of Obstetricians and Gynecologists (ACOG) on state policies on the shackling of incarcerated women reports that only 19 states and the District of Columbia provided physicians the authority to order the removal of shackles. [24] According to the same report, only 13 states broadly restricted the use of restraints throughout pregnancy, labor, delivery, postpartum, and transport. These states include California, Connecticut, Nebraska, Illinois, Kentucky, Louisiana, Maine, Maryland, Minnesota, North Carolina, Oklahoma, Texas, and Utah. The remaining states had differing policies concerning the use of restraints, when restraints can be used, and even whether the presence of correctional personnel during the delivery process is required. Only 9 states required the accompanying correctional personnel to remain outside of the delivery room for concerns of privacy. At the time that I encountered this patient, no federal or national laws or regulations were passed addressing the use of shackles on incarcerated pregnant women.

While state laws are in place to regulate, limit, or prevent the use of shackles on incarcerated pregnant women, compliance by correctional personnel and even medical professionals remains a central issue. With the lack of compliance, incarcerated women placed in shackles may not know the state laws pertaining to the use of shackles on them and therefore lack the ability to advocate for themselves due to their status as incarcerated. An article published in a 2019 copy of the *New York Times* titled "She Was Forced to Give Birth in Handcuffs. Now Her Case is Changing Police Rules", is an example of how despite regulations provided from state policy, compliance of the policies for the use of shackles on pregnant women remains an issue.[25]

The article tells the story of a woman who was held at a jail in the Bronx when she went into labor. She was transported to the hospital in both handcuffs around her wrists and shackles around her ankles, continued to labor and even delivered with at least one arm shackled. At this time the state of New York restricted the use of shackles during transport, labor and delivery, the postpartum period, and provided physicians the authority to remove the restraints. Therefore, according to the facts of this story outlined by the article, the officers present during this case were not compliant in following those policies against the use of shackles provided by the state. The patient received a financial settlement and the associated police department was forced to revise their procedures for the management of pregnant incarcerated women.

Several other states have recorded and settled legal actions taken by patients as a result of being shackled during their pregnancy and/or delivery. In 1983 at the Niantic Correctional Institution in Connecticut, a group of inmates and pretrial detainees brought forth a lawsuit in *West v Manson* against the correctional facility for violation of the

Eighth Amendment which included among other issues, the use of shackles during their pregnancy.[26] The case ended in a settlement for which the U.S. District Court of Connecticut found that the group of plaintiffs "clearly prevailed", however details of the accused violations were never fully provided to the public.

The use of shackles for pregnant incarcerated women is justified by the belief that they somehow pose a risk to themselves or others during the labor and delivery process and to prevent escape while outside of correctional facility grounds. The use of shackles to protect the patient from themselves or others is not supported by any precedence other than the inaccurate view of incarcerated individuals being "violent" or more capable of violence than the non-incarcerated population. The majority of women are incarcerated for nonviolent acts and have not displayed any violent behavior toward themselves or others during their time of incarceration leading up to and during their labor and delivery. According to the Federal Bureau of Prisons inmate statistics, as of March 2020, 63.7% those currently incarcerated, men and women, 63.7% committed nonviolent crimes, 45.4% of those were drug offenses, and only 3.2% for homicide, aggravated assault and other violent crimes.[27] Therefore, the idea that incarcerated women are inherently more violent than the general population is unfounded in the reported data and therefore no support is provided for the reasoning to shackle pregnant women.

In 2004, a woman at the Arkansas Department of Corrections was shackled during her labor course resulting in the legal case of *Nelson v Correctional Medical Services*.[28] According to the report on the case, the patient was handcuffed and placed in leg restraints during transport, the laboring process, and immediately following birth. The restraints were only removed when blood draws were made and during the delivery at the

request of the physician. The involved officer was asked specifically about the perceived threat risk of the patient in this situation. The officer testified that at no point while accompanying the patient did they feel "threatened." In addition, the patient was incarcerated for credit card fraud with no known history of violent behavior to justify the use of shackles due to a potential or perceived threat.

The filed suit claimed that the officer's failure to remove the restraints resulted in cruel and unusual punishment leading to preventable permanent nerve injury that evaluation by an orthopedist concluded was a result of shackle use. The case concluded with a ruling in favor of the patient with the district court stating that a reasonable officer "would have known that shackling legs to a bed post while [the patient] was in labor, without regard to whether she posed a security or flight risk violated her Eighth Amendment rights." The patient only received $1.00 in compensation for the injuries suffered, associated medical fees, and legal fees.

The example of the patient in the case of *Nelson v Correctional Medical Services* is reflective of the majority of pregnant incarcerated women who are subject to shackling during their pregnancies due to an unfounded perceived notion of somehow being violent in nature. The American Medical Association in 2015 stated that "the use of shackles to restrain a pregnant woman during the birthing process is a barbaric practice that needlessly inflicts excruciating pain and humiliation"[29] provides that the only justifiable reasoning for the use of shackles, highlighted in the legal cases discussed, to "inflict pain and humiliation."

The infliction of pain by the use of shackles on pregnant women is supported by the position ACOG announced in their Committee Opinion number 511 in 2011,

addressing Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females. ACOG states that "physical restraints interfere with the ability of health care providers to safely practice medicine by reducing their ability to assess and evaluate the mother and the fetus and making labor and delivery more difficult."[30] Their final position is that "shackling may put the health on women and fetus at risk."

Along with ACOG's statement on the shackling of pregnant women, the health effects of restraint use are specifically outlined. For example, it is well known that nausea and vomiting is common in the early stages of pregnancy. Most cases of nausea and vomiting resolve into the second trimester of pregnancy and few will require hospitalization for fluid and electrolyte repletion. To add additional discomfort to the already uncomfortable experience of nausea and vomiting associated with pregnancy is as ACOG states, "cruel and inhumane." For a woman who is pregnant, a simple fall and proper breaking of that fall with use of one's own body would be non-emergent, however for a pregnant woman, the same simple fall without the ability to properly protect can lead to serious complications for the mother and fetus. Medical evaluation can be significantly delayed, as present in the case of *Nelson v Correctional Medical Services*, where the removal of the shackles is required for an emergent evaluation or interventional to be performed.

Another issue present with the use of shackles on pregnant women is the inconsistency across states in policies and provisions concerning the use of shackling. In 2018, the Formerly Incarcerated Reenter Society Transformed Safely Transitioning Every Person Act (FIRST STEP act) presented as a bi-partisan effort to improve the criminal justice outcomes for those convicted and attempt to reduce the federal prison population.

A year later in 2019, the act was signed into law including provisions on the use of restraints on pregnant women who are in the custody of the Bureau of Prisons and U.S. Marshall Service. The major flaw in this act is still allowing correctional officers to shackle pregnant woman if they believe doing so is necessary to prevent acts of harm or escape with the ability for a physician to order the removal of the shackles still regulated at the state level. Therefore, the judgement of the correctional officer to determine the danger and threat risk of the patient is still use to justify the use of shackles. In addition, this act only applies to those women in federal custody and does not apply to state and local facilities where the majority of women in custody are. In a report by the Bureau of Justice in 2016, it was found that 12,614 women were in federal custody while 88,842 were in custody at the state level, not including those held at the local level.[31]

CHAPTER 5: PRISON NURSERIES

The adverse effects that incarcerated pregnant women face, including the use of shackles, extend beyond the duration of the pregnancy to include the postpartum period. It is reported that 75% of the women incarcerated were the primary caregivers to young children and that women age 24 or younger make up 48% of federal prisons and 55% of women within state facilities are mothers and the number of children with a mother behind bars doubled from 1991 to 2007.[32] According to a 2004 report by the National Resource Center on Children & Families of the Incarcerated, 2.7 million children in the U.S. have an incarcerated parent, half are under the age of 10 years old, 11.4% of the reported children are African American, 3.5% are Hispanic, compared to 1.8% are white.[33]

Compared to children with incarceration fathers, children of incarcerated mothers are more likely to be placed in foster care or within government services. In fact, 25% of children are placed in the custody of their fathers when their mother is incarcerated compared to 90% of children who remain in the custody of their mother when the father is incarcerated.[34] Therefore, when a father is incarcerated, the mother – child relationship is maintained, which studies have shown that despite issues that occur as a result of a single—parent household, maintaining a child with their mother has better outcomes for the child. Compared to a father being incarcerated, when the mother is incarcerated, those children are at an increased risk of experiencing the stress of poverty, placement and movement in numerous homes and schools, and academic struggles.[35] In fact, a 1973

study found that separation from mothers is traumatic for children regardless of the age of the child at or during the time of the mothers incarceration.[36]

Even just a year sentence, and therefore separation of child and mother, has significant detrimental effects on the child. In a sample of 35,000 children of incarcerated women serving sentences of less than a year, their children's home and/or school placements were disrupted at least twice within that year.[37] A 2005 study found that children with an incarcerated mother had significantly lower IQ scores.[38] Adolescents of incarcerated mothers drop out of high school at a rate three times that of their peers and are six times more likely than their peers to go to jail. Despite the fact that our current prison population is majority male and therefore potentially more fathers than mothers incarcerated, the effects of a mother being incarcerated a significantly more detrimental to the future and outcomes of children.

In 1901, the Bedford Hills Correctional Facility in the state of New York began an in-prison nursey program to stop the practice of separating mother from the newly born child. Bedford Hills Correctional Facility is credited for not only beginning the first prison nursery program, but serving even until today as a model for such. A prison nursery is a program that allows a child born to an incarcerated woman to remain in the care of their mother for a finite amount of time within the correctional facility, separate from the general inmate population. Beginning at Bedford Hills Correctional Facility in 1901, prison nursery programs became common until the 1950s when due to restructuring of funding, Bedford Hills stood as the only remaining correctional facility with a prison nursery program available by the 1970s.

According to the Women's Prison Association (WPA), 12 prison nurseries are currently available across 11 states including New York, Delaware, California, Texas, Illinois, Indiana, Ohio, Nebraska, South Dakota, Washington, and West Virginia. The capacity and duration of time the child is allowed to stay with the mother varies from each nursery program, by the mother's length of sentencing, and the convicted or past convicted crime. Universally, the programs require no active drug use by the participating mothers as well as no evidence or history of violent behavior which could threaten the safety of the child and other participants in the program. Across the differing nursery programs, the average length of stay is 12-18 months, with the lowest capacity of 5 mother and child pairs at the Decatur Correctional Center in Illinois and the highest capacity at Bedford Hills Correctional Facility in New York with 29 mother and child pairings.

In opposition to prison nursery programs, some argue that it is unsafe for the child to be housed with the mother in a prison and that long-term developmental effects will occur as a result of the child spending their first days to months of life in a prison. The prison nurseries currently operating do so as a separate unit that is closed to and secured from the general prison population. Pictures of the units show what looks to be a nursery and not what is thought of as a prison. While each of the prison nursery programs has its own eligibility requirements to participate in the program, universally all require that the mother not be convicted of a violent crime and have no past history of child abuse or neglect. Therefore, there is no increased risk of danger or harm to both the mother and child participating.

Multiple studies have attempted to identify any potential adverse effects on children as a result of spending their first days to months of life housed with their mothers in a prison nursery program. The 1992 Catan study compared infants who were housed with their mothers in prison nursery and infants who were separated from their incarcerated mothers at birth and placed into either the care of family members or social services. This study found that the infants housed in the prison nursery remaining in the care of their mothers showed a stronger and healthier attachment to their mothers resulting in improved developmental and emotional outcomes.[39] A more recent study in 2014, Preschool Outcomes of Children Who Lived as Infants a Prison Nursery, further evaluated for any potential intellectual adverse effects that may occur. Out of 111 children followed in this study, 47 children spent their first 1-18 months in a prison nursey, while 64 of the children were separated from their incarcerated mother at the time of birth. The two groups were followed to preschool age and it was found that the children who were able to be with their mothers in the prison nursery had significantly lower anxiety and depression issues, lower scores evaluating for withdrawn social behavior, and no increased behaviors in aggression or increase in rates of Attention Deficit Hyperactive disorder (ADHD).[40]

The 2016 Committee Opinion Number 511 issued by ACOG states that "it is important to avoid separating the mother from the infant. Prison nurseries or alternative sentencing of women to community-based noninstitutional settings should be considered."[41] ACOG also reaffirms in this statement that for the women who participate in the prison nursery programs, "their children show no adverse effects as a result of their participation." ACOG further supports the use of prison nurseries in order to allow for the

early life interaction between mother and child which is a critical period for infant development, most importantly including the option to breastfeed.

Prison serves the purpose to punish those convicted of committing crimes set forth by laws, removal of that person from society with the thought of preventing them from further committing crimes, rehabilitating those individuals with time removed from the general public, and serving as a deterrent for individuals in our society to commit crimes. The rehabilitation part of prison function is highlighted by the interchangeable reference to prisons as correctional facilities. If prisons are to be viewed as corrective with the purpose to rehabilitate and individual to rejoin society as productive members, then methods proven to do so need to be practiced. The use of prison nurseries can and has been proven to serve as a correctional and rehabilitative method for women who are pregnant and give birth while incarcerated.

The idea of prison nurseries as correctional is supported by a 2009 report published by the Women's Prison Association (WPA) which focused on the participants in the Nebraska Correctional Center for Women. This report included 43 mothers and their 44 infants, finding that those women who were able to participate in the prison nursery program with their children had a 13% reduction in misconduct reports, a recidivism rate of 9% compared to 13% of the general prison population, and no positive testing for drug use during their time in the nursery.[42] The same report conducted a survey of these mothers and found that 95% of participants reported feeling a stronger bond with their child and 49% reported higher self-confidence and self-esteem. Even at a five year follow up of the women included in this survey, 57% of these mothers retained custody of their children.[43]

If the purpose for prisons is "correctional" then in the case of incarcerated women who pregnant, give birth while incarcerated and allowed to maintain a relationship with their children, are likely to undergo a process of rehabilitation for which they were sentenced to undergo. For incarcerated mothers like Destiny Doud, who was incarcerated at the Decatur Correctional Center in Illinois in 2018, the opportunity to stay with her newly born child instead of separated at the time of birth "reminds me that I have something that's great now. Something to live for." [44] The experience of motherhood itself can be used as a correctional and restorative method for rehabilitation.

The experience of motherhood alone is a proven effective rehabilitative method practiced by prisons for incarcerated women, but the prison nursery programs extend such correctional and rehabilitative methods beyond the participating mother. Many of the prison nursery programs offer education and training in child development, parenting skills, child advocacy, support groups, and lactation education and support for participating mothers. Bedford Hills, for example, offers a summer camp allowing for the existing children of the mother at the time of incarceration to visit their mothers. This is significant as 75% of incarcerated mothers are the primary caregivers to young children, who then most likely are in state or family custody. The Nebraska Correctional Center for Women requires those mothers participating in their nursery program who do not have a high school degree, to complete a general education diploma (GED). The Washington Correctional Center for Women operates the Early Head Start program which provides the participating infants with additional care as their mothers undergo education and training to help transition them to life outside of prison.

CONCLUSION

When I encountered the patient who was shackled to the bed, the immediate sight of her pregnant body restrained by handcuffs and guarded by two armed officers unveiled to a practice that exists within our society, for which as a future physician will affect those that I dedicate my life to serving. From this experience I began to understand the history and nature of the specific unjust treatment of pregnant women who are incarcerated. Even with the legal precedence established from the ruling of *Estelle v Gamble* and the test of deliberate indifference to identify injustice in healthcare delivered to prisoners and protect prisoners for injustices in healthcare, women and pregnant women who are incarcerated continue to face issues that directly put their lives and the lives of their unborn children at risk.

Mass incarceration is a practice within this country targeting for the removal of bodies from our society to a confined system of control and in doing so has targeted women and their motherhood. The idea to target for the removal and elimination of a group is seen in the efforts toward targeting mothers and potential mothers of that group. The number of complications published in which incarcerated pregnant women have suffered as a result of negligence of providing healthcare reveals is unacceptable in medical practice and therefore should not be tolerated just because a person is incarcerated.

Solutions are available and some are in practice with evidence and data to support their necessity and success. Prison nurseries, the FIRST STEP act, and individual state laws on shackling are evidence of progress made toward eliminating the targeted attacks on incarcerated pregnant women and mothers. From here, work is needed to not only

address and improve the current systems and practices for the care of incarcerated pregnant women. In order for such measures to start and continue to progress, incarcerated pregnant women must be brought to the forefront of social justice communities, studies, and activism.

Physicians and healthcare providers must understand the state laws in place in order to optimize the care given to incarcerated pregnant women. These same physicians and healthcare providers must also extend their practice directly to prisons and correctional facilities, a practice which today is minimal and as shown from previous data, nonexistent. Hospitals and administrations must formulate their own policies and regulations for the care of incarcerated pregnant women within their facilities supported by an understanding of the specific issues they face and how to best care for them. Prison and correctional facilities must follow the recommendations provided by organizations such as ACOG, to understand their own role in optimizing the health of the pregnant women while in their custody and under their care.

Major limitations of this work include my status as a medical student at the time of this writing and lack of experience beyond the encounters of incarcerated pregnant women within a hospital setting. Therefore, I wish to continue to expand my own understanding of the issues discussed and develop as an advocate for incarcerated pregnant women within my own practice as a future Ob/Gyn through my training in residency and with direct experience within a prison and/or correctional facility.

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